Sample 837 Scenarios

The sample scenarios are for test and education purposes. The information is test data and does not represent actual insurance carriers, employers, injured employees, or health care providers. The information may appear to be real or confidential information. However, this is done in order to ensure the test data passes validation edits.

Cancellation - DME using HCPCS Codes
(Includes P/A #, Referring Provider, Multiple Adjustment Reason Codes per line item and PPO Contract)

Darlene Davidson is a single female, born 06/04/69. She lives at 5720 Green Drive, Dallas, TX 72309. Her telephone number is (214) 836-5527 and her social security number is 224-17-3272.

Darlene works at Bagels, Etc located at 234 Main Street, Dallas, TX 72314. Bagel, Etc's telephone number is (214) 472-1462 and their FEIN is 59-7654321. Bagels, Etc's policy number is 147643A472.

Darlene's treating doctor is James A. Boudreaux, M.D. and his license number is MDJ1234TX.

- On 09/18/02 Darlene fell off a ladder at Bagels, Etc. and suffered broken bones and a head injury.
- On 08/24/03, Medical Supplies, Inc. sent supplies to Darlene's home, where she was receiving home health care. Darlene's patient account # is 470077.

- On 09/03/03 Medical Supplies, Inc., located at 2700 Medical Dr., Dallas, TX 72311, submitted an original bill to Texas Insurance Company for the total charged amount of $575.02. Texas DME suppliers do not have a license #; however, Medical Supplies, Inc.'s provider type and jurisdiction, DMETX, is required along with their name in box 31.
    - E1399, NU, KI, charged amount was $550.00, pre-authorization number assigned by Texas Insurance Company was 0011
    - A4320, charged amount was $25.02

- The billing provider is Austin Billing Company located at 23 Dove Street, Austin, TX 78200 and their FEIN is 34-5678912.

- On 09/06/03 Texas Insurance Company received the bill.

Texas Insurance Company has a contract with Medical Supplies, Inc. to pay in accordance with the contract, unless the contract amount exceeds the TWCC Medical Fee Guideline (MFG), in which case the paid amount will be made in accordance with the MFG. Texas Insurance Company's claim number for Darlene is 1400714D.

- On 09/10/03 payment was made in the amount of $572.00:
    - E0730, NU, KI, $550.00
    - A4320, $22.00 with ARC 131 and ARC 45.

Texas Insurance Company is required to report all medical bill payment information to the Texas Workers' Compensation Commission (TWCC). Texas Insurance Company is located at 100 North River Drive, San Angelo, TX 75234. Their FEIN is 76-5332244.

- On 09/23/03, Texas Insurance Company sent a transaction to TWCC, covering a reporting period of 08/02/03 – 09/15/03.

The unique bill id number assigned by Texas Insurance Company is 456465.

Cancellation Scenario – Insurance carrier reported bill in error. The insurance carrier is submitting a Cancellation transaction "02". Unique Bill ID must match to a previously submitted "00" original bill.
On 11/23/03, Texas Insurance Company sent a transaction to TWCC, covering a reporting period of 08/02/03 – 09/15/03.

TX 837 - Scenario 1

PLEASE DO NOT STAPLE IN THIS AREA

Texas Insurance Company
100 North River Drive
San Angelo, TX 75234

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Darlene Davidson

3. PATIENT'S BIRTH DATE MM DD YY: 06 04 69 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Bagels, Etc.

5. PATIENT'S ADDRESS (No., Street): 5720 Green Drive

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]

7. INSURED'S ADDRESS (No., Street): 234 Main St.

CITY: Dallas STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: Dallas STATE: TX

ZIP CODE: 72309 TELEPHONE (Include Area Code): (214) 836-5527

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 72314 TELEPHONE (INCLUDE AREA CODE): (214) 472-1462

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 1400714D

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY: 09 18 02 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: James A Boudreaux, M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: MDJ1234TX

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 820.
2. 873 9
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 0011

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
08	24	03	08	24	03	12		E0730	NU, KI	1,2	550 00	1				
08	24	03	08	24	03	12		A4320		2	25 02	6				

25. FEDERAL TAX I.D. NUMBER SSN EIN: 34-5678912 [X]

26. PATIENT'S ACCOUNT NO.: 470077

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 575 02

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 575 02

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Medical Supplies, Inc.
DMETX
09/03/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
Medical Supplies, Inc.
2700 Medical Dr.
Dallas, TX 72311

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Austin Billing Co.
23 Dove Street
Austin, TX 78200